Office of Inspector General

Illinois Department of Public Aid

Annual Report
Calendar Year 2000

George H. Ryan
Governor

Robb Miller
Inspector General

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January 31, 2001

To the Honorable George H. Ryan, Governor, and Members of the General Assembly:

I am proud to present you with my annual report for calendar year 2000. Since its inception in 1994, the Office of Inspector General has introduced new strategies and new approaches to help assure the integrity of human service programs in the state of Illinois.

The annual report documents the OIG's innovations and provides, as required by Public Act 88-554, data on payments to medical providers at various earning levels, audits of medical providers, savings generated by the prescription Refill-Too-Soon program, sanctions against providers and investigations.

I hope that you will find the report informative and useful.

Sincerely,

Robb Miller, CFE
Inspector General

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Background

Introduction

The General Assembly created the Office of Inspector General (OIG) within the Illinois Department of Public Aid (DPA) in 1994 and mandated the Inspector General (IG) "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct" in programs administered by DPA. In its first six years, the OIG has performed its duties, sharpened its vigilance and pioneered innovations that have attracted national attention. The focus has been to increase the emphasis on preventing fraud and abuse from occurring in the first place. All of OIG's advancements have been achieved because of the staff's commitment to team building within the office, within DPA and with the many public agencies that share the OIG's goals.

Duties

The OIG investigates misconduct in programs administered by DPA and since 1997, the Illinois Department of Human Services (DHS). The OIG enforces policies of the two agencies and the state of Illinois. The agencies' programs include Medicaid, KidCare, food stamps, cash assistance, child care and other social services. The OIG each year conducts thousands of oversight activities, which include financial audits, physician quality of care reviews, Medicaid eligibility reviews, internal investigations of employees and contractors, fraud prevention research, welfare fraud investigations, Medicaid provider sanctions, restriction of recipients who abuse their Medicaid privileges, employees' safety, building security and special projects aimed at specific problems.

Using experiences from its investigations, reviews and audits, the OIG has strived to build a foundation of prevention strategies to combat fraud and abuse. The OIG's approach has been to study, to learn and to respond to trends and actions that challenge the integrity of human service programs in the state of Illinois. The Payment Accuracy Review and Fraud Prevention Investigations are two of many examples in which research has led to actions that have helped to deter fraud and abuse.

Staffing

An authorized total of 311 staffers, including investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers, information specialists and an administrative staff, comprise the OIG team.

The OIG has realized from its start that it could not prevent fraud and abuse on its own. To be effective in the long run has required a commitment to team building, to working with partners and to finding collective approaches to assure program integrity. The team approach has been most effective with the OIG's primary partner, DPA's Division of Medical Programs (DMP).

Independence

The Office of Inspector General occupies a unique place within the human services branch of state government. Although the OIG is under the DPA banner and budget, the office is independent of the

agency. The Governor appoints the IG to a four-year term, which requires confirmation by the Illinois State Senate.

Independent by creation, cooperative by practice describes the OIG's standard for meeting its statutory responsibilities and duties. Every DPA Director and DHS Secretary has acknowledged the OIG's independence. Agency directors and their staffs have maintained lines of communication and have been supportive of the shared mission to promote program integrity while assuring access to medical and financial assistance for citizens in need. During its existence, the OIG has strived for the proper balance between independence and cooperation, between program integrity and the public's access to aid.

National Perspective

The OIG's innovations in fraud prevention and fraud research have attracted attention beyond the state of Illinois. National interest in the OIG's achievements has validated the office's strategies and its use of time and resources to examine issues and devise workable, productive solutions. National recognition has had another positive effect, further encouraging the OIG's best efforts to detect fraud and abuse.

In 2000, the IG and OIG staffers made presentations on non-emergency medical transportation to the U.S. Department of Justice's National Advocacy Center, on Medicaid integrity and fraud research to Congress's General Accounting Office, on the Illinois Medicaid Payment Accuracy Review to the Association of State Medicaid Directors and on Medicaid integrity to the U.S. House Budget Committee's Task Force on Health Care.

To learn what is happening in other states and on the national level, OIG employees have been active in the Association of Inspectors General, a national group supporting the work of IG's at local and state levels, and in the federal Health Care Financing Administration's Medicaid Fraud and Abuse Technical Advisory Group (TAG). The OIG staff also has played active roles in the National Welfare Fraud Directors Association, the United Council on Welfare Fraud, the National Health Care Anti-Fraud Association and the National Association for Program Information and Performance Measurement.

Federal Integrity Review

The first in the nation program integrity review by a federal agency praised DPA for its "commitment to excellence" in combating Medicaid fraud and abuse. The four-person review team working under the auspices of the federal Health Care Financing Administration (HCFA) examined DPA's operations and issued a laudatory report in August 2000. The team focused on the agency's Medicaid procedures in place and those under development.

The report represents a seal of approval for what DPA's DMP and the OIG have accomplished and plan to accomplish. Besides finding the department and the OIG in full compliance with federal laws and regulations, the review team found much to praise. The team's positive reaction and the fact that Illinois was chosen as the first state to be examined strengthen Illinois' reputation for innovation and professionalism in thwarting Medicaid fraud and abuse.

The federal team's report said:

> "The state agency has taken many pro-active measures necessary not only to identify abusive provider payments, but also to prevent them from occurring in the first place. Especially noteworthy is the weaving of the 'think-tank' mentality with exceptional internal and external interaction among entities dealing with program integrity issues. This environment creates a culture conducive to effectively fighting fraud and abuse by leveraging technology and tapping the collective experience of various staff members. This produces results, such as trend development, the identification of problem providers, and the creation of policies designed for the prevention and collection of overpayments."

The report further said:

> "The review team found that the state of Illinois is complying with all of the required Medicaid program integrity laws and regulations as outlined in the review guide. The state has an inspiring working relationship with its MFCU (Medicaid Fraud Control Unit) and is performing many functions in an innovative way that pushes the state's Medicaid program integrity processes to a high level. The state also has demonstrated a noteworthy capacity to initiate pro-active activities that have further elevated its program integrity operations. The state is proposing many other initiatives to enhance its fight against fraud and abuse, which the review team feels can be enriched with the incorporation of the proposed enhancements."

The report singled out an OIG bureau for praise: "The very existence of the Bureau of Fraud Research (BFR) constitutes a best practice. The BFR continues a long-standing tradition within DPA/OIG of engaging innovative fraud detection investigations in the Medicaid program. . .The 'think-tank' mentality that drives the unit has sparked innovative efforts. . ."

The entire federal report, entitled *HCFA Program Integrity Review Report*, can be read on the OIG's web site at www.state.il.us/agency/oig under Fraud Research and Related Information.

PIONEERING PREVENTION STRATEGIES

Pioneering fraud and abuse prevention in Illinois human services has been at the center of OIG activities. The Payment Accuracy Review, Fraud Prevention Investigations and Medicaid Fraud Prevention Executive Workgroup are among the unique OIG initiatives that have and continue to build new and better pathways to program integrity. Those new paths have led to fresh perspectives and better tools to help ensure taxpayer dollars go where they are intended and most needed – to helping individuals and families become healthy and independent.

The traditional pay and chase approach to program integrity has been effective to a degree, but it has

not always been effective stopping fraud and abuse from occurring at the front end before services are delivered and payments made. Pay and chase efforts stand out because calculations of success are relatively easy: so many people caught, so many dollars collected. The tallies represent hard, identifiable numbers. The savings from prevention measures may be challenging to calculate, but that doesn't mean the savings are any less real.

The benefits of prevention can match and often exceed the more traditional approaches. Stopping taxpayer dollars from going to the wrong medical provider or the wrong client before fraud and abuse occur provides immediate savings. That's why prevention measures are a priority at the OIG. All the prevention strategies share a common goal of pinpointing the red flags of impropriety, then devising effective responses to stop specific practices from leading to abuses. It's a detect and deter approach. The goal is to halt fraud-prone behavior before it occurs among providers and clients. Over the last few years, the OIG has sharpened its ability to do that with its prevention initiatives, which have been aided greatly by emerging technology. Doing the research and implementing the changes to prevent fraud and abuse take enormous amounts of staff time and resources. Hundreds of health care fraud schemes have been identified by OIG from its research and studies. The time is well spent because the staff learns more about the dynamic nature of fraud and abuse and how to respond better and faster to ensure program integrity in the long term.

PAR's National Attention

Completed in August 1998, *The Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement*, generated national interest in 2000. The ground-breaking study determined that DPA correctly spends 95.28%, plus or minus 2.31% of the dollars paid to providers. The Illinois accuracy rate exceeded Medicare, for which four separate studies have set an accuracy range of 86-93%, and surpassed the Texas Medicaid rate of 89.5%.

Because Illinois was the first state to do a payment accuracy review, it has drawn attention from Congress, from the Association of State Medicaid Directors and from individual states planning similar projects. The Illinois project would not have been possible without the long-standing and effective teamwork of DMP and OIG staffs. PAR serves as a baseline against which DPA and the OIG will be able to measure the accuracy and integrity of Medicaid for years to come. PAR also is a good example of how OIG prevention strategies and solutions evolve.

Non-Emergency Medical Transportation

PAR, which found a high degree of irregularities in non-emergency medical transportation, prompted a follow-up study, *Non-Emergency Medical Transportation Reviews: Focusing on Compliance*, published in December 1999. The study found: more than 6,000 discrepancies in the 12,000 services examined, one third of the services claimed were not supported by acceptable records, nearly half of the services could not be linked directly to a corresponding Medicaid service and possibly one third of the money paid to transportation providers should have been withheld. The problem areas involved record keeping, prior approvals, billing for excessive mileage and billing for nonexistent or non-medical transportation.

PAR and the December 1999 study followed two examinations of Medicaid transportation providers, one done by the Illinois State Police and the other by the OIG in 1997. All four studies led to a series

of actions, such as making sure that transportation providers actually existed and were providing services, making sure the providers billed Medicaid correctly and sending notices to let providers know what is expected of them.

Further, DMP in 2000 developed a request for proposals to hire a private vendor to process prior approvals for non-emergency medical transportation, evaluated the proposals and awarded the bid to a firm. The OIG has been an active partner in this entire process, reviewing proposals, offering suggestions and participating in contract negotiations to increase the level of validation required of the vendor. The earlier research and analysis done by the OIG clearly contributed to the understanding and the need to improve practices and procedures to ensure integrity of Medicaid transportation dollars.

Fraud Prevention Investigations (FPI)

The FPI program has expanded and matured since its introduction in fiscal year 1996. All 23 DHS local offices in Cook County now participate, up from the five offices in the original pilot. The program's goal is to prevent ineligible persons from receiving welfare benefits, thereby saving tax dollars. In five years, the FPI program has proven its value to help ensure the integrity of public assistance programs in Illinois and to increase savings for Illinois taxpayers. Since FPI's inception, the program has completed 9,402 investigations, taken actions in 59 percent of the cases and posted an estimated total net savings of nearly $23 million.

DHS's Division of Community Operations, working with the OIG, uses error-prone criteria to spot questionable applications. DHS local office staff refer these applications to the OIG for pre-eligibility investigation. A private investigation firm under contract with the OIG completes the investigations within five to eight days, depending on the type of case. If the suspicions are founded, DHS local offices deny applicants assistance or reduce their benefits.

A report issued in November 2000 set forth FPI's most recent fiscal year achievements. Compared to the previous year, the program experienced an increase of nearly 122% in the number of annual investigations and a more than 92% increase in annual net savings. FPI posted the largest annual savings of $8.7 million during its fifth year, a savings of $11.60 for every dollar spent on the program. The OIG's Bureau of Investigations (BOI) calculated the estimated annual net savings for Temporary Assistance for Needy Families, Medicaid and food stamps.

Medicaid Team Building

The Medicaid Fraud Prevention Executive Workgroup (MFPEW) is a perfect example of team building with team results. The idea of the workgroup surfaced in September 1996 when senior members of OIG and DMP met to discuss ways to use the Medicaid Management Information System to track and prevent fraud. In January 1997, the DPA director approved formal creation of the executive-level oversight group to ensure reasonable and prudent measures are undertaken to detect and deter Medicaid fraud and abuse. A Deputy Inspector General and the Deputy Administrator of the Division of Medical Programs co-chair the group's monthly meetings attended by staff from both areas as well as staff from DPA's management information systems. Deputy Administrator Fred Sapetti's knowledge, hard work and cooperative spirit contributed to MFPEW's many achievements. He retired in December 2000 after 35 years of dependable, commendable service to DPA.

In its four years, MFPEW tackled such issues as spiked payments, non-emergency medical transportation reviews, undeliverable mail, expired medical license monitoring, provider settlement agreements and Diagnostic Review Group upcoding among many other issues. The group's work has resulted in onsite provider reviews, recommendations, edit changes, policy changes and development of profiling criteria. One vital element that has emerged from the group's work is the team spirit among the MFPEW's members. By sharing ideas and information on a monthly basis, the group has proven it can successfully explore emerging problems and devise solutions.

Refill-Too-Soon

During 2000, MFPEW initiated a change in the Refill-Too-Soon (RTS) program that promises significant savings. RTS is an editing process within the DPA's Medicaid pharmacy claims system. The workgroup initiated an informational edit to determine the extent to which pharmacies refill prescriptions before the recipient's entire supply has been used. For example, if a recipient had a prescription refilled on day 23 of a 30-day supply, seven excess tablets would remain. The previous RTS policy allowed excess medication to remain when a prescription was filled at the established threshold. The new RTS policy will compute the threshold on the days carried over from the prior prescription plus the number of days in the new prescription.

The workgroup could not estimate the annual savings from the change, but did project $1.1 million in savings when the policy was applied in a one-month test of pharmacy claims.

New Provider Verification

New Provider Verification (NPV) is a MFPEW initiative which aims to verify a provider's existence and office address as reported on the Medicaid enrollment application.

In October 1999, CBS' 60 Minutes broadcast *Knee Deep in Fraud*, which focused on how California's Medicaid health care system suffered fraud by phony storefront operations becoming providers to fake sales through their billing practices. The presentation brought national attention to an area already under scrutiny in Illinois by the MFPEW, which had begun exploring why a large volume of DPA mail was being returned from providers as undeliverable.

The OIG, in conjunction with DPA's Bureau of Medical Administrative Support, implemented a project in February 1998. This pilot study, which reviewed 280 new providers and their enrollment addresses, was completed in May 1998. Of the total, 74% matched DPA records and 26% did not. In two cases, the providers could not be found.

Under the auspices of the MFPEW, the OIG began onsite post-enrollment visits in March 2000 for certain newly-enrolled Downstate Durable Medical Equipment and transportation providers to verify their existence and legitimacy. Onsite visits allow the department to:

- Verify the provider's existence.
- Prevent potentially fraudulent claims.
- Verify current data and reduce returned mail.
- Establish a positive relationship with the provider.

- Respond to record-keeping questions and educate the provider.

The OIG performed the six-month pilot by visiting selected providers within three months of enrollment. At a minimum, the visits included an interview with providers and an inspection of their premises to confirm their existence and inventory. Cook and surrounding collar counties were included in the project in October 2000.

Information from the visits, such as needed assistance with billing, corrected provider phone numbers and addresses, goes to DMP for handling. If potential fraud has been detected, the OIG evaluates the matter and takes action to investigate or to refer, as required by state and federal statutes.

MFPEW also has created a study group, which has begun exploring the possibility of doing pre-enrollment verification before new providers file Medicaid claims with DPA.

Death Notification Project

A workgroup led by the OIG and including DMP and DHS' Division of Community Operations issued a report in February 2000 on its findings and recommendations to ensure more timely notifications to DPA and DHS by nursing homes when Medicaid residents die. Recent reports by the OIG and the Office of Auditor General have documented problems with the notification system. Delays in death notifications have resulted in overpayments, which are, in effect, interest-free loans to nursing homes. The overpayments, however, are eventually recovered through an automated reconciliation process.

The overpayments have been a subject of OIG study for some time. In a review of 963 deaths in the fourth quarter of Fiscal Year 1997, the OIG established that on average a client's case record was not corrected for 171 days after the date of death and that overpayments totaled $1.1 million for the period. In 1998, DPA and DHS took steps to strengthen the reporting requirement for nursing homes and to implement a safety net by using Social Security Administration data on deaths.

The new workgroup's primary study goals were to identify whether nursing homes or DHS local offices were responsible for late case cancellations and to pinpoint weaknesses in the death notification system. Began in August 1999, the study focused on 26 nursing homes with the highest incidences of overpayments involving late death notices. These facilities represented 627 clients whose deaths occurred between January 1, 1999 and June 30, 1999. Each case had already been canceled. The cases were split nearly equally between those with payments after death and those with no overpayments. A random sample of 239 cases with the same proportions was drawn. The review involved 16 DHS local offices covering these 26 nursing homes. The bulk of the cases were in Cook and DuPage counties.

Poor record keeping at long nursing homes and DHS local offices was a major impediment to conducting the study. Nursing home files were missing 21% of the death notification forms (DPA 1156). DHS local offices could not find 24% of client case files (the entire file was missing). Of the DPA 1156s located at nursing homes, only 38% were located at the DHS local offices. For cases canceled by a DHS local office, only 40% of the DPA 1156s could be located. The findings cover only the 26 nursing homes with the highest incidences of overpayments due to late death notices, not all facilities.

The workgroup concluded it is common to find there is no one party solely at fault. Any contention by these nursing homes that they acted timely was unfounded by this project. The lion's share of responsibility for late cancellation of cases due to death lies with providers. First, no evidence existed that the facility completed a DPA 1156 in 21% of the cases. In the remaining cases, 27% were completed within the required five days and 73% were completed beyond five days. It appears that most nursing homes are not submitting the DPA 1156 to DHS' Exception Processing Unit (EPU), as now required.

Since the issuance of the report in February 2000, the following actions have been taken:

- DMP sent an informational notice to all nursing homes reminding them of the requirement to fax patient status changes to the EPU within five days of the change and to maintain the fax confirmation sheet as evidence of submission.
- The OIG sent letters to the 26 nursing homes putting them on written notice of the study's findings.
- The OIG met with the DMP and two nursing home trade associations, the Illinois Health Care Association and the Illinois Council on Long-Term Care. The consensus was that the Long Term Care Electronic Data Interchange system will resolve most, if not all notification problems.
- The DMP developed a corrective action plan, which the OIG has been monitoring.
- The OIG devised a new audit program to identify which facilities are not timely reporting deaths and sent letters to nursing home associations advising them of the changes.

Managing Medicaid Data

The department and OIG began in 2000 implementing far-reaching enhancements to the Medicaid Management Information System (MMIS), which serves as the primary processing system for the Illinois Medical Assistance Program. The enhancements will improve MMIS' overall efficiency and keep abreast of emerging patterns and trends involving providers and recipients. Also, the enhancements will ensure quality of care and strengthen the OIG's ability to develop new fraud and abuse detection measures. The enhancements include:

- Data Warehouse, which will contain up to five full years of Medicaid data, including paid claims, rejected claims, diagnosis and procedure codes, provider, recipient, payee and drug information. OIG will use the Data Warehouse to explore Medicaid data, both prospectively and retrospectively, do provider and recipient analysis and respond to requests from state and federal agencies.

- Decision Support System/Executive Information System (DSS/EIS) and software tools for data analysis and data mapping. DSS/EIS will help executives, managers and others obtain integrated data at various geographical levels and present the information for investigative purposes.

- Data Mining, which will provide advanced analytical capabilities beyond those provided by the Data Warehouse. The tool will provide exploratory data analysis and will detect subtle patterns and relationships in the data.

- Case Administration System and Enquiry (CASE), an automated computer system that will track and monitor cases under OIG review. A request for proposals has been written to procure a vendor to develop CASE. Development is projected to begin in Fiscal Year 2001, with system completion anticipated in Fiscal Year 2003. CASE will embrace all areas of OIG, including internal and external investigations, audits and reviews. CASE also will centralize maintenance and storage of data used in case review and tracking. The system will track the progress of each case and make possible the electronic transfer of all the information necessary for analysis, correspondence and final action.

- Client Server/Surveillance Utilization Review Subsystem (CS/SURS), which will help analyze and monitor DPA's $6 billion annual medical assistance budget. CS/SURS will make utilization review, quality assurance and medical claims management information retrieval and reporting more flexible and more cost effective. The system will do statistical analyses to help ensure Medicaid beneficiaries receive acceptable levels of care. CS/SURS also will provide information for fraud and abuse detection.

Random Claims Sampling

The Random Claims Sampling (RCS) Project aims to develop a payment accuracy measurement system based on OIG's Payment Accuracy Review (PAR), the first-ever review of payment accuracy in a state Medicaid program. RCS will establish an ongoing system to ensure that every paid claim faces a chance of review. The system will:

- Provide periodic estimates of payment and service accuracy rates to help focus enforcement and detection efforts.
- Increase the chance perpetrators face scrutiny beyond those identified by current activities.
- Deter erroneous and fraudulent billings.
- Identify vulnerabilities in Medicaid to guide fraud and abuse detection.
- Provide a database to develop models to identify erroneous billings more accurately and rapidly.

Using the decisions made in PAR as its starting point, the OIG has been field testing alternative review and measurement strategies. The lessons learned from the field tests will be used to design the operational measurement system. Once the RCS is operational, it will review about 1,800 cases per year.

Electronic Listing of Sanctioned Providers

The OIG launched a new feature on its web site in November 2000 – a list of terminated, suspended and barred Medicaid providers and those who have voluntarily withdrawn from the program. The listing, which will be updated monthly, provides medical employers an easier way to check on whether an applicant, employee, administrator, operator, contractor or advisor has been sanctioned by DPA.

The Illinois Medical Assistance Program prohibits medical providers from having relationships with sanctioned individuals or entities. All Medicaid providers are required to be diligent in checking the status of potential employees. If a medical provider hires a person or entity from the list, no Medicaid

payment may be made for any items or services.

The new Internet listing means better access to information and less paperwork for providers and the department. A provider can check the list at www.state.il.us/agency/oig 24 hours a day, seven days a week rather than writing a letter or having to wait until regular business hours to call for information. Under this new system, a provider also can send an e-mail to the OIG webmaster to obtain more information. In its three months of operation, the web site attracted nearly 1,000 visitors.

Some 850 names of individuals and businesses covering the last 20 years appear on the Internet list. Also available on the OIG web site are links to the Illinois Department of Professional Regulation's list of license holders and disciplinary reports and to the U.S. Department of Health and Human Services' list of excluded individuals and entities under Medicare.

Providers checking the OIG list are advised not to take any action on a particular person until the status has been verified by the OIG. Requests for more information can be sent via our web site which is located at www.state.il.us/agency/oig . The department is notifying providers, health care associations and HMOs via provider notices and informational letters about the web site.

Settlements

The OIG participated in the settlement of eight Medicaid/Medicare fraud and abuses cases during 2000. The state's share of the settlements was $11.5 million. The five largest cases were:

- Dr. James Desnick and the now-defunct Doctors Hospital of Hyde Park were accused of submitting false claims for the treatment of Medicaid and Medicare beneficiaries between 1993 and 1999. Desnick served as chairman of the hospital board and was its principal shareholder. The settlement negotiated by the U.S. Attorney's office in the Northern District of Illinois amounted to $14 million, with the state's share being $7 million.

- The University of Chicago Hospital was accused of submitting claims for Medicaid and Medicare that were wrongly coded between 1993 and 1998. The U.S. Attorney's office in Chicago and the Illinois Attorney General's office negotiated a settlement of $10.5 million, of which $2,625,000 was the state's share.

- Genentech, Inc., was accused of submitting false and fraudulent claims for its drug, Protropin, used for the long-term treatment of children who have growth problems. Illinois' share of the national settlement was $663,941.

- Advanced Medical Transport of Peoria was accused a billing for ambulance services when it was not medically necessary between 1991 and 1997. The U.S. Attorney's Office in the Central District of Illinois negotiated a settlement of $2.1 million, with $595,109 being the state's share.

- LTC Pharmacy of Minonk was accused of returning unused medications to its inventory without crediting DPA, as required by law. The U.S. Attorney's Office in the Central District

of Illinois negotiated a settlement amounting to $1 million. The state's share was $275,000.

INVESTIGATIONS

Teamwork with Law Enforcement

Teamwork involving the private and public sectors was at the heart of case that stopped $707,776 in Medicaid funds from being paid to a transportation provider and led to a wider state investigation of alleged fraud during 2000. A Chicago bank teller became suspicious when a person attempted to cash a state warrant for Medicaid transportation services with the wrong endorsement.

The OIG as well as Illinois Treasurer's Office, Illinois Comptroller's Office, Illinois Department of Commerce and Community Affairs, the Illinois Attorney General's Office and the Illinois State Police Medicaid Fraud Control Unit played roles that led to the freezing of all payments to a Medicaid provider. Because of quick action and cooperation by all those involved, the provider did not receive a penny of Medicaid funds.

The case also prompted a wider investigation of the principals in an allegedly fraudulent Medicaid transportation ring in the Chicago area. So far two persons have been indicted, and the case remains under investigation by the Illinois State Police.

To meet its overall mission, the OIG places a high value on teamwork with all its law enforcement partners throughout the state. Although the OIG is statutorily authorized to conduct criminal investigations, the office is not a law enforcement agency. Therefore, the OIG recognizes it must work closely with state and federal law enforcement and prosecutors to be effective and successful. The examples are:

- Medicaid Fraud: The office participates in health care fraud task forces in the three federal districts in Illinois. The office has assigned a full-time investigator to the Medicaid Fraud Control Unit in Springfield and provides additional critical administrative support to state and federal investigators and prosecutors.
- Welfare Fraud: The office refers hundreds of welfare fraud cases to local prosecutors every year. Two full-time OIG investigators have been assigned to the State Financial Crimes Task Force. This task force is a multiagency, white-collar investigative team housed in FBI offices and commanded by the Illinois State Police.
- Internal Security: The office works closely with the Illinois State Police, Division of Internal Investigation on criminal allegations of employee or contractor misconduct. Since 1994, the office has investigated nearly 1,200 cases. The office also presents criminal cases to prosecutors.

Operation Talon

Starting in 1997, the Office of Inspector General for the U.S. Department of Agriculture created Operation Talon to apprehend fugitives who are illegally receiving food stamps. DPA's OIG matches DHS food stamp clients against wanted persons files. Law enforcement agencies so far have captured 781 fugitive felons, primarily in Cook County.

Welfare Fraud

- A Chicago woman received public aid under two aliases while she was employed. She also used another alias to obtain homemaker payments while providing care for her spouse. The concealment of her employment, receipt of public aid with false identities and receipt of fraudulent homemaker payments led to an overpayment of nearly $172,000. The case was referred to the Cook County State's Attorney's Office.

- A Cook County woman did not report that her employed spouse lived with her and that they shared joint assets. Investigators discovered the husband owned and managed a grocery store, the couple owned their home and had bank accounts and certificates of deposit. The couple also filed joint income tax returns while the wife received public aid. The client received more than $81,000 in overpayments. The case was referred to the Cook County State's Attorney's Office.

- An employed woman receiving medical assistance and food stamps for her and child, falsified documents to obtain benefits for her under an alias and a nonexistent child. The client collected more than $49,000 in excess benefits. The investigation also revealed she used an alias to receive housing assistance from the U.S. Department of Housing and Urban Development. The department investigated and referred the matter to the Illinois Attorney General office, which will coordinate criminal prosecution with the state's attorney.

Employee Misconduct

- A Public Administration Intern falsified her timekeeping records in 1999 and 2000. The Bureau of Internal Affairs (BoIA) could document six instances in which she failed to work the number of hours shown on the time sheet. She admitted to falsifying timekeeping records, but could not recall the dates or the number of times. The intern resigned her position with DPA, waived all reinstatement rights and agreed not to seek or accept future employment with the state of Illinois. She reimbursed DPA the equivalent of 15 days available benefit time, worth $1,474.48.

- A Health Facilities Surveillance Nurse worked several secondary jobs during the hours she was employed by the state. BoIA issued a subpoena to a hospital and an employment agency to obtain all personnel and payroll records pertaining to the nurse's employment. Automatic Wage Verification System inquiries disclosed the employee received income from the hospital in calendar year 2000. BoIA determined the nurse was employed intermittently at the hospital as a staff nurse. She began work with the employment agency in April 2000. A review of payroll records from showed the nurse worked at the hospital or on agency assignments on or before 3 p.m. in about 90 instances. There were also several days on which the nurse reported at the hospital or other jobs early in the morning when she was supposedly at her job at DPA. An analysis of personnel attendance records revealed several days for which she submitted sick leave in the afternoon and reported to work at other employment at or before 3 p.m.

  Calculations determined the employee defrauded the agency a minimum of 180.25 hours. The employee's travel vouchers for this period were reviewed. False entries were made by the

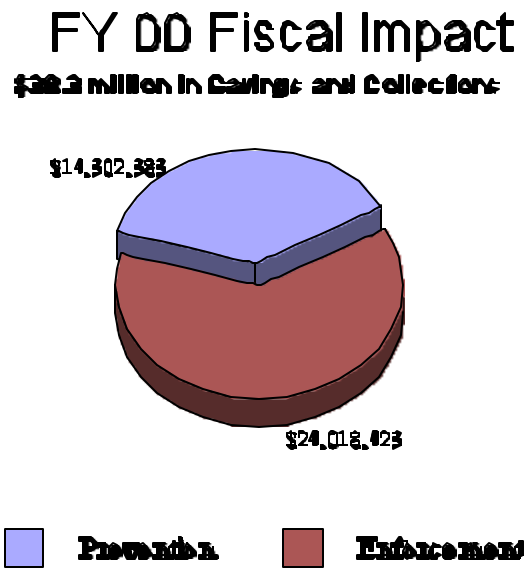
employee on those days she reported for work at the hospital at or before 3 p.m., but was purported to be on travel status until 5 p.m. These entries accounted for $180.99 in fraudulent travel reimbursements. The nurse acknowledged the employment conflict and resigned her state position with no reinstatement rights and agreed to not seek or accept future state employment. She reimbursed the agency $4,662.01 from her available benefit time as restitution.

- An investigation determined an Executive I violated numerous DPA rules and policies. The employee did not comply with instructions to report his employment with DPA and his earned income to his caseworker at a DHS local office. At his client interview, he failed to notify the local office of his employment with DPA. Also, the employee grossly misrepresented his employment history on his promotional application (CMS 100B) dated October 14, 1998. He failed to acknowledge a 1978 conviction for misdemeanor theft when he completed his CMS 284. He allegedly committed two felony crimes, which were pending in criminal court. The first court case resulted from an incident in which he allegedly forged the signature of a judge to an official document. The other felony arrest resulted from his conduct following a traffic stop by the Illinois State Police. After the case was submitted to Labor Relations, further allegations of misconduct by the employee were reported to BoIA. During this supplemental investigation, it was determined he had engaged in criminal conduct by violating a fiduciary trust of power of attorney for an elderly woman. BoIA developed evidence he had defrauded the woman of more than $48,000 by converting her funds to his personal use. The evidence and a summary of findings were submitted to the state's attorney. The employee pled guilty to forgery and theft over $300 and was sentenced to 30 months' probation, ordered to pay court costs, a $30 per month probation fee and to make restitution of $41,500 to the victim. This information was turned over to the Office of Labor Relations, and the employee was discharged for cause.

- A DHS caseworker was accused of altering payroll stubs from her employer to qualify and receive subsidized child care from the state of Illinois. The investigation determined that between July 1995 and July 2000, the caseworker received $6,430.31 in child care benefits to which she was not entitled. The caseworker submitted fictitious payroll stubs to a DHS contractor hired to provide child care payments to eligible recipients. The fictitious stubs reflecting a lower earnings allowed the caseworker to receive child care benefits while employed by DHS. There is credible evidence the caseworker may have committed State Benefits Fraud (720 ILCS 5/17-6) as the result of her actions. This case was forwarded to the Illinois State Police for further investigation. The caseworker resigned her position with DHS, effective September 22, 2000. An involuntary offset has been initiated to recoup the $6,430.31 the caseworker appears to have unlawfully obtained from the agency.

Fiscal Impact

To assure the financial integrity of human service programs within its purview, the OIG embraces a broad spectrum of prevention and enforcement activities. The fiscal impact of those activities can measured by comparing the amount expended against the collections and cost avoidances. In Fiscal Year 2000, the OIG operated under a budget of $19.6 million and collected or avoided costs totaling $38.3 million.



- Prevention Activities:
  Recipient Restrictions
  Fraud Prevention Investigations
  Medicaid Fraud Prevention Workgroup
  Fraud Science Team
  Payment Accuracy Review Measurement

- Enforcement Activities:
  Provider Audits
  Client Fraud Investigations
  HMO Marketing Misconduct
  Provider Sanctions
  Medicaid Quality Control Reviews
  Food Stamp Disqualifications
  Physician Peer Reviews
  Internal Investigations

Conclusion

The collections and cost avoidance can be attributed to the team building that has occurred within the OIG and with OIG's many partners during the last six years. The team building has contributed to:

- Heightened awareness of how, when and where program integrity is under threat.
- Multifaceted, multi-agency solutions to strengthen program integrity.
- Broader understanding of the importance of program integrity.
- More public confidence that tax dollars do the most good for the most in need.

The OIG's achievements could not have been realized without the ongoing support, encouragement and involvement of all our partners, both agencies and individuals, all of whom have made commitments of time and resources to build better program integrity within the state of Illinois' human services sector.

# # #

OIG Published Reports

Title	Date	Description
Fraud Prevention Investigations: FY00 Cost/Benefit Analysis	**November 2000**	**Identified an estimated $8.7 million in net savings with a benefit of $11.60 for every dollar spent. Estimated savings during the first five years is $22.8 million.**
Death Notification Project	**February 2000**	**Identified responsibility for late death notice cancellations for nursing home residents and recommended improved reporting.**
Non-Emergency Medical Transportation Reviews: Focusing on Compliance	**December 1999**	**High-paid transportation providers' claims examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in record keeping, prior approvals, billing for excessive mileage and billing for nonexistent or non-medical transportation.**
Project Care: Exploring Methods to Proactively Identify Fraud	**December 1999**	**Targeted assistance cases with multiple children for whom one or more had not received medical care. Identified ways applicants created fictitious children.**
Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments	**December 1999**	**Recommended methods by which non-institutional postmortem payments could be identified more quickly.**
Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century	**September 1999**	**Verified the cost-effectiveness of searching for assets of LTC applicants.**
Recipient Services Verification Project: RSVP II-Home Health Care	**August 1999**	**Confirmed receipt of home health services by clients.**

Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues	**June 1999**	**Validated the effectiveness of the project's error-prone criteria and processes.**
Fraud Prevention Investigations: FY98 Cost/Benefit Analysis	**December 1998**	**Identified an estimated $4 million in net savings with a benefit of $14.25 for every dollar spent.**
Maintaining a Safe Workplace: Examining Physical Security in DPA and DHS Offices	**October 1998**	**Examined DPA/DHS security weaknesses and proposed changes**
Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement	**August 1998**	**First every such study in the nation. Identified DPA accurately expends 95.28%, plus or minus 2.31%, of total Medicaid dollars.**
Medicaid Client Satisfaction Survey: October 1996-September 1997	**July 1998**	**Measured client satisfaction with quality and access in both fee-for-service and managed care.**
Postmortem Medicaid Payments: Identifying Inappropriate Provider Payments on behalf of Deceased Clients.	**April 1998**	**Confirmed LTC client cases were not being canceled timely, causing overpayments to nursing homes and made recommended improvements.**

Fraud Prevention Investigations: FY97 Cost/Benefit Analysis	**February 1998**	**Identified an estimated $3.63 million in net savings with a benefit of $13.02 for every dollar spent.**
Medical Transportation: A Study of Payment and Monitoring Practices	**December 1997**	**Identified policy changes and monitoring strategies**
Funeral and Burial: A Review of Claims Processing Issues	**October 1997**	**Examined policies and procedures of DHS to pay for client funeral and burial and recommended improvements.**
Maintaining a Safe Workplace: Best Practices in Violence Prevention	**June 1997**	**Identified best practices to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.**
Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings	**May 1997**	**Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the state millions of dollars.**
Fraud Science Team Development Initiative Proposals	**April 1997**	**Proposed a multiphase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative postpayment review routines to detect inappropriate payments.**
Medicaid Client Satisfaction Survey: April-September 1996	**April 1997**	**Measured client satisfaction with quality and access in fee-for-service and managed care.**

Prior Approval Study	**May 1996**	**Surveyed nine state Medicaid agencies and six private payors to understand their drug prior approval systems. Also, reviewed prior approval statutes, rules, regulations and literature.**
Clozaril Report	**February 1996**	**Studied distribution and payment for the anti-psychotic drug Clozaril and recommended improvements.**
Hospital Inpatient Project Summary Report	**April 1994**	**Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.**

# # #

STATISTICAL TABLES

Audits of Medical Providers

The OIG initiates medical audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Medical audits generally cover an 18-month period and are conducted on institutional and non-institutional providers. When a provider is selected for an audit, the provider is contacted, and records are reviewed onsite by the audit staff. Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, a negotiated settlement or the DPA Director's final decision. The provider may repay the department by check or by a credit against billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary, and the amount reported will often cover audits closed in previous quarters. Collections generally result from audits completed in prior periods. Note: Effective July 1, 1999, collection amounts are taken from a new source – the Public Aid Accounting System (PAAS).

Collection of Overpayments
CY 2000

Audits	339
Collections	$14,419,204

Collection of Restitutions

Monies collected are from fraud convictions, provider criminal investigations and civil settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Collections of Restitutions
CY 2000

Amount Collected	$1,374,938

Refill Too Soon

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid prescription claim. The estimated savings represents the maximum amount the department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescriptions expires. The estimated savings shown in this table represents the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon Program
CY 2000

Total Number of Scripts	19,724,540
Amount Payable	$862,540,098
Scripts Not Subject to RTS	1,225,017
Amount Payable	$36,115,080
Scripts Subject to RTS	18,499,523
Amount Payable	$826,425,018
Number of Scripts	834,075
Estimated Savings	$43,473,738

Provider Sanctions

The OIG acts as the department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Provider Sanctions
CY 2000

Hearings Initiated	
Termination	60
Suspension	15
Denied Application	4
Recoupment	39
Termination/Recoupment	18
Decertification	11
LTC/Hospital Assessment	8
Child Support Sanctions	139
Total	293

Providers Sanctioned	
Termination	40
Voluntary Withdrawal	9
Suspension	6
Denied Application	5
Recoupment	11
Termination/Recoupment	6
Decertification	2
LTC/Hospital Assessment	0
Child Support Sanctions	59
Negotiated Settlements	26
Other P.A. 88-554 Sanctions	0
Total	164
Cost Savings	$1,057,640
Cost Avoidance	$874,730

Client Eligibility Investigations

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public aid. Investigation results are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to a state's attorney or a U.S. attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Clients who intentionally violate Food Stamp Program regulations are disqualified for12 months for the first violation, 24 months for the second violation, permanently for a third violation and 10 years for receiving duplicate assistance.

Client Eligibility Investigations
CY 2000

Investigations Completed	1,154
Estimated Overpayments	
Grant and Food Stamps	$2,453,019
Medical	$172,808

Types of Allegations	
Employment	21%
Family Composition	30%
Residence	6%
Interstate Benefits	2%
Other Income	6%
Assets	9%
Multiple Grants	1%
Other	25%
Total	100%
Food Stamp Disqualifications	1,131

Child Care Investigations

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results are provided to DHS' Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. attorney.

Child Care Investigations
CY 2000

Investigations Completed	81
Overpayment Identified	$564,011

Client/Vendor Prosecutions

The OIG conducts investigations and refers cases of serious crimes involving large financial losses to a state's attorney or U.S. attorney for criminal prosecution. These cases may involve multiple cases with false identities, failure to report income, long term fraud involving the circumstances of the client and other instances that have resulted in large overpayments to undeserving individuals.

Client/Vendor Prosecutions
CY 2000

Prosecution	
Accepted for Prosecution	109
Overpayment on Cases	$1,349,258
Convictions	66
Restitutions Ordered	$586,283
Acquittals	0

Medical Abuse Investigations

Medical Abuse Investigations

The OIG investigates allegations of abuse of the Medical Assistance Program by clients. Abusing clients may be placed in the Recipient Restriction (RRP) program. The restriction process begins with a computer selection of clients whose medical services indicate abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies. Abusing clients may choose to enroll in an HMO as an alternative to RRP. Cost avoidance is calculated by comparing the funds expended on behalf of the client before restriction to post restriction expenditures. It does not include the cost avoidance amounts for clients opting for HMO enrollment to avoid restriction. Cost avoidance dollars are estimated and based on the number of recipients restricted or locked in at the end of the calendar year.

Medical Abuse Investigations
CY 2000

Medical Overutilization	
12 Months	
Recipient Reviews completed	4,146
Recipients Restricted for 12 months as of 01-01-00	816

Recipient Restrictions Added	555
*Recipient Restrictions Released	526
Recipient Restricted for 12 months as of 12-31-00	845
24 Months	
Recipient Re-evals completed	536
Recipients Restricted for 24 months as of 01-01-00	221
Recipient Restrictions Added	160
*Recipient Restrictions Released	74
Recipient Restricted for 24 months as of 12-31-00	307
Recipients opting for an HMO vs. Restriction as of 01-01-00	125
Recipients opting for an HMO vs. Restriction as of 12-31-00	72
Cost Avoidance for FY 2000	$5,578,063

*Releases are a result of: cancellation of Medicaid eligibility, death of recipient, opting to select an HMO or program compliance.

HMO Marketer Investigations

The OIG monitors marketing practices to ensure clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The DPA's Bureau of Managed Care maintains a toll-free complaint hotline from which the majority of referrals are received. Marketers found guilty of misconduct are removed from the DPA's HMO Marketer Register, which lists HMO marketers from whom the DPA will accept enrollments.

HMO Marketer Investigations
CY 2000

Types of Allegations	
Fraud	134
Misrepresentation	17
Unethical Practices/Other	13
Total	164
Findings	
Substantiated	54
Unsubstantiated	27
Unable to Determine	83
Total	164

Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. The investigators are not sworn, do not carry firearms and do not have arrest powers. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses and contract violations. Investigations often reveal violations of several work rules or criminal statutes. A single investigation may cite several employees or vendors. Discipline may include resignation, dismissal, suspension or a reprimand.

Internal Investigations
CY 2000

Investigations Completed	
Substantiated	156
Unsubstantiated	46
Total	202

Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	9%
Failing to Follow Instructions	1%
Negligence in Performing Duties	4%
Engaging in Business with a Client	0%
Incompatible Outside Interests	4%
Sexual Harassment	2%
Release of Confidential Agency Records	2%
Misuse of Computer System	4%
Falsification of Records	9%
Other Work Rule Violations	4%
Work Place Violence	11%
Criminal (Work Rules)	
Misappropriations of State Funds	3%
Attempted Fraud or Theft	4%
Commission of or Conviction of a Crime	7%
Other	4%
Public Assistance Fraud Offenses ILCS Chapter	4%
Criminal Code Offenses ILCS Chapter 720	25%
Contract Violations	2%
Total	100%
Misconduct Cited	
Employees	84
Vendors	12
Total	96
Levels of Employee Discipline	
Discharged	13
Resigned	19
Suspensions	15
Other, such as reprimands	29
Administrative Action Pending	156
No Action Taken	31
Total	263

APPENDIX – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

Data showing billing and payment information by provider type and at various earnings or payment levels can be accessed at www.state.il.us/agency/oig/pdffiles2/aggregate.pdf. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.

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Q = Quarterly Reports
A = Annual Reports

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www.state.il.us/agency/oig

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TTY 1-800-447-6404